

## Off-Unit Transport Documentation

- I-056 *Inmate Transfer Roster*
- Transport of Offender Form

## Transport of Offender

This form will be completed by the Lieutenant on duty each time an offender is transported off unit to include when a unit vehicle is loaned to other units. This form will be turned into the Building Major's Office.

Date: 8-13-11 Van # (If Applicable): 152096 Incident Number (If Applicable): I-11520-08-11

Offender(s) Information			
Name	<u>James, Kenneth</u>		TDCJ # <u>1726849</u>
Name			TDCJ #
Reason/Cause for Transport			
Reason:		Cause (Injury, Assault, etc.):	
<input type="checkbox"/> Scheduled Appointment <input checked="" type="checkbox"/> Emergency <input type="checkbox"/> Pick-up <input type="checkbox"/> Other		<u>medical emergency</u>	
Off-Unit Location			
<input checked="" type="checkbox"/> Palestine Regional Medical Center <input type="checkbox"/> Beto Medical HUB <input type="checkbox"/> UT Health Science Center <input type="checkbox"/> ETMC Tyler <input type="checkbox"/> Hospital Galveston <input type="checkbox"/> Other: _____ <input type="checkbox"/> Skyview Unit <input type="checkbox"/> Mother Frances Hospital <u>If to a free-word medical facility, follow OMT instructions below!</u> <input type="checkbox"/> OMT Command Center called at 888-456-5556 <input type="checkbox"/> OMT Command Center Fax Sent/Or Email to HQTN002			
Free-World Hospital Contact Person:			
Name	Title		Time
Method of Transport			
<input type="checkbox"/> Unit Van <input checked="" type="checkbox"/> EMS			
Transport Officer Information			
Name	<u>R. Byer</u>		Rank <u>COV</u>
Name	<u>R. Mangan</u>		Rank <u>COV</u>
Name			Rank
Departure/Return Information			
Date/Time Out: <u>8-13-11 / 0340</u>		Date/Time In (If returned during same shift) <u>N/A</u>	
Offender Returned to Unit: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Vehicle Security (Complete this section when transporting by Unit Van):			
Every transfer vehicle shall be checked for external and internal security before any offenders are loaded on the vehicle. In addition to the routine searches, (i.e. searching for contraband and items that pose a security risk) the following items will be checked. Transfer Officer will initial once completed and prior to departing the unit.			
Initial Each Item when Completed	<u>KB</u>	All bars and screens over windows as well as between the officer and offender compartments shall be checked to ensure that none are loose or missing.	
	<u>KB</u>	All security bars, screens, cages and locks are working properly and nothing is loose or missing.	
	<u>KB</u>	The vehicle shall be checked to ensure that it contains a fire extinguisher.	
	<u>KB</u>	The vehicle tires shall be given a visual inspection including the spare and jack.	
<u>KB</u>	The 2-way radio shall be checked to ensure that it is operating properly.		
Offender Search/Restraint Procedures			
Supervisor and the Transfer Officers will Sign, Print Name and Title Indicating completion of each of the following:			
The offender will be strip-searched by one (1) of the Transfer Officers under the direct supervision of a security supervisor.		Supervisor (Print, Sign, Rank) <u>W. H. ... LT</u>	Transfer Officer (Print, Sign, Rank) <u>R. Byer COV</u>
Under the direct supervision of a security supervisor, the restraints (leg irons, restraint belt, leg chain, handcuffs and handcuff restraint box) will be placed on the offender by one (1) of the Transfer Officers. The supervisor will check all restraints to ensure the offender is properly secured.		<u>W. H. ... LT</u>	<u>R. Byer COV</u>
The Transfer Officer and security supervisor shall review the transporting offenders' travel card for any security precaution designators (escape/assault history) and any other similar criteria relevant to security.		<u>W. H. ... LT</u>	<u>R. Byer COV</u>

Lieutenant's Printed Name/Signature: W. H. ...

Revision: 10/01/2010

**TEXAS DEPARTMENT OF CRIMINAL JUSTICE  
INSTITUTIONAL DIVISION  
INMATE TRANSFER ROSTER**

Transferring Unit: Prepare five (5) copies of this roster for each unit that is to receive men. Send original and duplicate with men being transferred. Triplicate: Attach to your daily strength report and mail to W.H. Gaston, Director, Personnel Records. Quadruplicate: Attach to your file copy of the daily strength report. Fifth copy: Inmate record section.

Receiving Unit: You must receive two copies of this form with each group of men transferred to your Unit. Original attach to your daily strength report.

Transfer From Gurney

EFFECTIVE DATE OF CHANGE

Transfer To PRMC

8-13

20 11

Prison Number	Last	Name First	Middle	Race	Class	Remarks Reason for Transfer	
1726849	James,	Kenneth		B		Medical	1
							2
							3
							4
							5
							6
							7
							8
							9
							10
							11
							12
							13
							14
							15
							16
							17
							18
							19
							20

Gurney  
Shipping Unit

8-13  
Date

20 11

PRMC  
Receiving Unit

## UTMB Correctional Managed Care Report

- Facility Death Review for Total Quality Management
  - Attachments

This Information is privileged and confidential and is prepared and distributed in accordance with  
Vernon's Annotated Civil Statutes, Health and Safety Code, Chapter 161.032 and 161.033

*final*

## UTMB CORRECTIONAL MANAGED CARE FACILITY DEATH REVIEW FOR TOTAL QUALITY MANAGEMENT (TQM)

PATIENT NAME: Kenneth W. James  
DATE OF BIRTH: 11/25/1958  
DATE OF INCARCERATION: 8/10/2011  
8/10/2011  
DATE AND TIME OF DEATH: 8/13/2011 @ 04:16 by Dr. Heidi Knowles @ PRMC  
FACILITY: Gurney

TDCJ-ID #: 1726849  
AGE: 52  
DATE RECEIVED ON UNIT

### Documentation Reviewed (check all appropriate boxes):

TDCJ / UTMB Medical Records	<input checked="" type="checkbox"/>	Physician's Death Summary		Other:	
Community Hospital Records	<input checked="" type="checkbox"/>	Preliminary Autopsy Report			
Video Tape		Final Autopsy Report			

### Persons Interviewed / Title:

1. D. Washington LVN
2. D. Rinehart LVN
3. S. Smith PA
4. P. Rayford Major
- 5.

### Administrative Check List:

	Date Completed:
Death Notice to TDCJ Divisional Director of Health Services within 72 hours	8/13/2011
Custodial Death Report to UTMB Death Record Technician within 10 days	
Death Summary completed within 30 days	
Death Certificate completed and signed	
Complete Medical Record to Death Record Technician within 30 days	

### PATIENT CASE SUMMARY (may attach Death Summary for items covered in that document):

Current Diagnoses: cardiac arrest

### Current Medications:

Vasotec 10 mg - 1 tab bid  
Hydrodiuril 25 mg - 1 tab q day  
Inderal 10 mg - 1 tab bid

Relevant Medical History: HTN, Lumbar Laminectomy x 2, Bilateral Inguinal Hernia Repair

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Summary of Events on the Day of Death:

02:40 – Officer Glorie Harris CO IV notified LT. Whitfield that Offend James was urinating on himself and was ill

0243 – Officer Torrance Stephens CO V and Kenneth Mangan CO IV respond with w/jeelchair and transport Offender James to the Unit Medical Department

0245 – RN McKnight at the Beto Unit was notified by Sergeant Tully Flowers of Offender James situation. RN McKnight advised to transport Offender James to Beto for evaluation

02:47 – Offender blood pressure taken by security 89/57, T 108

0248 - Lt. Whitfield is notified of the offender's condition and he notifies central control to call 911 for emergency services

0250 – RN McKnight is advised that Lt. Whitfield has called 911 to respond.

0251 – Lt Whitfield arrives at the medical department and he advises Sergeant Seda to move the offender into the emergency room and place on gurney. Lt. Whitfield checks for a pulse and feels one.

0318 – EMS arrives at back gate

0319 – EMS ambulance arrives at the back door of medical department.

0320 - Lt Whitfield briefs paramedics on offender's condition.

0323 – Lt Whitfield receives a phone call from the 911 operator (Sarah Wardell) informing him an air ambulance was en-route.

0327 - Offender transferred to EMS gurney

0328 – Offender James was moved from the emergency room to the back door of the medical department and placed in the ambulance.

0330 – Paramedics request assistance from an Officer McKnight to assist with life saving measures.

0338 – Ems departs unit en-route to PRMC with code in progress

0416 – Dr. Heidi Knowles M.D. pronounced Offender James deceased

NOTE : \*\*\* ETMC helicopter was 5 minutes out from Gurney but did not transport Offender James due to code in progress\*\*\*\*

Summary of Nursing Actions / Events prior to Death:

8/10/2011 – Pt received @ back door from county – c/o pain lower back, r- leg

8/12/2011 – 11:45 - Pt seen in medical for Intake physical exam by S. Smith PA  
v/s: BP 170/107, Wt. 254, H 71 in, P 108, R 18, T 96.7  
Ordered: chest x-ray, lab, and EKG  
Restrictions: III – 11,12,14

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CCC HTN in 30 days  
BP checks x 7 days

11:55 - D Rinehart LVN rec'd verbal order from S Smith PA for Clonidine 0.2 mg now  
0.2 mg Clonidine Administered – BP 170/100, P 108

12:30 – recheck blood pressure 129/74, P 100 – pt returned to provider to complete intake physical

17:40 to 18:00 approx. – D. Washington LVN received call from B Dorm (Officer Debra Gilmore) about Offender Kenneth James # 1726849. Mr. Washington LVN states he was informed Offender James was complaining of being dizzy. Mr. Washington states he informed Officer Gilmore to have Offender James drink water, stay as cool as possible, and if they thought Offender James needed to come to medical to have him come down.

19:00 – Clinic closed for the day – Offender James had not reported to medical

**Critical Nursing Care Issues:**

1. Was CPR initiated and maintained until assumed by EMS or patient was pronounced dead?  
☐ Yes ☐ No ☒ Not Applicable

*If CPR was not initiated, Explain:*

2. Did Nursing notify the Provider? ☐ Yes ☐ No ☒ Not Applicable  
*If No, Explain:*

3. Did Nursing function appropriately during the emergent phase?  
☐ Yes ☐ No ☒ Not Applicable  
*If No, Explain:*

4. Did Nursing determine any educational opportunities related to this event? ☐ Yes ☒ No  
*Identified Educational Opportunities:*

1. Remedial education for nursing staff on protocol when receiving call from security concerning patients

2.  
3.  
4.

5. Did Nursing determine any corrective action need(s)? ☒ Yes ☐ No  
*Identified Corrective Action Need(s):*

1. LVN D. Washington – retake the Protocol Implementation Class  
2. RN McKnight – In-service by Nurse Manager on Telephone Triage Protocol  
3.  
4.

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**Medical Staff Present During Terminal Event (if death occurred on a TDCJ facility):**

1 None

2

3

4

5

6

**Autopsy Findings (or attach autopsy report, enter N/A if autopsy not ordered, enter Pending if ordered but not received at time of review):** pending

**Significant Findings and/or Areas of Concern (*not addressed in nursing section*):**

Possible heat related incident

**Corrective Action(s) Implemented:**

1. LVN D. Washington – required to enroll and pass Nurse Protocol Implementation Class
2. RN McKnight – required to complete in-service on Telephone Triage Protocol

**Committee Members Present at Facility TQM Meeting:**

Name	Title	Date
Name	Title	Date
Name	Title	Date

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*(Not to be used for legal or medical purposes)*

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 DATE OF BIRTH: 11/25/1958 AGE: 52  
 DATE OF INCARCERATION: 8/10/2011 DATE RECEIVED ON UNIT  
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 DATE AND TIME OF DEATH: 8/13/2011 @ 04:16 by Dr. Heidi Knowles @ PRMC  
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**Documentation Reviewed (check all appropriate boxes):**

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**Current Medications:**

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Relevant Medical History: HTN, Lumbar Laminectomy x 2, Bilateral Inguinal Hernia Repair

Joseph Hutchins 1726848 B333

Two Days ago I watched  
him look like He had a Heat  
Stroke. You Put Water In here  
Before you came and Got him  
and Took him To medicale  
You Put him Back In Here  
The Next Day Then The Next  
Day He Is Dead.

( God Bless This man For his Life )  
( Since he Rescued. )

Chasen Brewer # 1725370 B3-34

All I saw was James going  
back and forth to his bunk and  
bench complain about the heat  
guard told him to go back to  
bunk one time the second time  
he got up they gave him assistance.

✓ Kenneth Smith # 172~~57~~32 B-B-15

The Lomate told Several officers  
that he didnt feel good and they told  
him that he would be ok he was sent to  
Medical and they sent him Right back

Kenneth Smith

GERARDO MARTINEZ #1622528

B3-03

LT. WHITFIELD.

THE GENTLEMAN IN BUNK 23 HAD ASKED FOR MEDICAL ATTENTION EARLY IN THE WEEK. SUFFER FROM HEAT EXHAUSTION. TONIGHT DURING COUNT HE WAS LYING IN BED HE LOOKED UNRESPONSIVE. THE OFFICER ON DUTY WAS WALKING AROUND HIM AS IF HE SMELLED HORRIBLE OR WAS INFECTED WITH SOMETHING. THIS WAS AT I.D COUNT TIME. LATER IN THE NIGHT WE ASKED FOR A MOP. IT LOOKED LIKE HE HAD URINATED ON HIMSELF.

Gary Lynn Jefferson #1726850

all I know is that he was acting like  
he had took something<sup>to</sup> make him sick  
and he started acting crazy Pissing on  
his self and not responding the way he  
should been when we came in here to  
get her from WACO

B3.19

To Lt whitfeild

B3-08

Robert Pruitt #1726822

I didn't see what happened I was  
asleep

To: G. Whitfield

I didn't see anything, I was asleep.

Andy Harlow # 1726844

B-3-05

David Hamilton

1723338

B-3-4

L. Whitfield

I went to sleep around 12:30 but I woke up  
and seen 23 Bunk on the toilet, I guess he didnt make it  
to the restroom because he urinated on himself and he  
sat on the bench in the dayroom looking hurt, and another  
man in here called for a guard to help

Lt Whitfield

Ryan Petty B-32 160542

I was sleeping.

To: L. Whitefield

I didn't see it

Anthony J. J. J.  
1725736

2  
3  
4

John Brown T.D.C. #1726236 B3-50 8/12/11

A offender James fall out his first day on the tank. And on Friday night A offender James wasn't feeling good he try to tell them his self but the just pull him off. Then other a offenders try to get the laws attention but they told them to go to bed. Then a offender in B3-24 try to tell the officers that ~~James~~ offender James didn't have ~~enough~~ air.

John Brown

TDC  
# 1724493 B-0-9

My name is Eddie Richardson This Inmate  
was sick he did tell ~~2~~ officers That  
he was hurting and was hot. They did not  
do nothing That was Friday. later That nite  
he started pissin on his self

WHITFIELD

Konkun Tarpah B3-10 1725364

I DIDN'T SEE  
NOTHING

Made Apart #1725729

B311

I Don't know what you all talkin  
I was a sleep

8-13-11

Home B-3 - 53

William J <sup>TDC # 1726242</sup> Davis

Did not see nothing

To Lt. Withfield

CARNEASE JOHNSON

1726881 B3-12

I ~~WAS~~ DIDNT SEE NOTHING

Lt. Whitfield

Bradford Moore 1725730 B-313

Don't know what those about  
To Lt. Whitehead  
Bradford Moore

To Lt Whitfield

William Brown Bank 14 #1727462

I didn't see anything.

ermene gildo graciano maderia

# 1724484

B 3-16

I didn't see anything.

Jimmy Jones  
B3-17

~~1725735~~  
1725735

I didn't ~~say~~ SEE anything? but he  
told the CO's all the time that  
he was hurt. didn't do anything  
for him but talk shit. Like  
Everybody lying, Derrick Pickens  
1725363? <sup>B3</sup> 18 bunk

Albert Rio #1564447

MAN, I DON'T KNOW WHATS GOING  
ON!

B9-70

CASE/SAMPLES 879236 B3-21

I was a sleep Lt i

Herbert Fress #1144502

I didn't see nothing I was sleep.

B3-22

Rodney Kuykendall

B3-26

I witnessed the man being in pain

ANTHONY DAWSON 1726272 #46

I SEEN NOTHING

I Avalon M. Butler 1726237, I  
Know nothing, I see nothing

8-13-2011  
Avalon M. Butler  
Pgs 3-51

Jeffrey Campos #1726239 B3-52

I was asleep. Didn't see anything.

Carlos Aguilar 1726403 B3 54

~~Did~~ Did Not see nothing  
to Lt Wittfield

To Lt Whitfield,

My name is Clint Dawson TDC # 1726839  
I was asleep I didn't see anything.  
B3-06

148

Bunk 24

I courtney Gordon #1727466 was sleep  
But It is too hot not enough Air

Rayo Peña 1725737  
B-327

I didn't see anything because I was asleep.

Chanthavong Aphsith Chaele

T.D.C.H 1727464

I. dot kwon nothing

B-3, 28

Marion W. #1725738

B3-29

I didn't see anything

St. Winfield

1726812

Thomas A. Gage B3-30

I didn't see anything

for

Johnny Hernandez  
TPC # 1726846 B3-31  
I didnt see anything

I was asleep and did not  
see anything.

Michael Tiller  
#1727480  
B335

Terrance Jennings B3-36  
1725373

I was sleep when events Transpire

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physical

17:40 to 18:00 approx. – D. Washington LVN received call from B Dorm (Officer Debra Gilmore)  
about Offender Kenneth James # 1726849. Mr. Washington LVN states he was informed Offender James  
was complaining of being dizzy. Mr. Washington states he informed Officer Gilmore to have Offender  
James drink water, stay as cool as possible, and if they thought Offender James needed to come to medical  
to have him come down.

19:00 – Clinic closed for the day – Offender James had not reported to medical

**Critical Nursing Care Issues:**

1. Was CPR initiated and maintained until assumed by EMS or patient was pronounced dead?

☐ Yes

☐ No

☒ Not Applicable

*If CPR was not initiated, Explain:*

2. Did Nursing notify the Provider? ☐ Yes ☐ No ☒ Not Applicable

*If No, Explain:*

3. Did Nursing function appropriately during the emergent phase?

☐ Yes

☐ No

☒ Not Applicable

*If No, Explain:*

4. Did Nursing determine any educational opportunities related to this event? ☐ Yes ☒ No

*Identified Educational Opportunities:*

- 1.
- 2.
- 3.
- 4.

5. Did Nursing determine any corrective action need(s)?

☐ Yes

☒ No

*Identified Corrective Action Need(s):*

- 1.
- 2.
- 3.
- 4.

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**Medical Staff Present During Terminal Event (if death occurred on a TDCJ facility):**

1. None
- 2.
- 3.
- 4.
- 5.
- 6.

**Autopsy Findings (or attach autopsy report, enter N/A if autopsy not ordered, enter Pending if ordered but not received at time of review):** pending

**Significant Findings and/or Areas of Concern (not addressed in nursing section):**

Possible heat related incident

**Corrective Action(s) Implemented:**

None

**Committee Members Present at Facility TQM Meeting:**

Name	Title	Date
Name	Title	Date
Name	Title	Date
Name	Title	Date

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Name	Title	Date
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Name	Title	Date
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Name	Title	Date
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Interoffice-Correspondence  
Danny Washington LVN  
08-17-11

This Interoffice Correspondence is in regards to Kenneth James, TDC # 1726849. On or about 08-12-11, at approximately 1800 hours, I received a call from the B-dorm in regards to Kenneth James. The officer stated that they had an inmate that was dizzy. I advised him to have the patient to drink water, stay as cool as possible, and if they thought that he, the patient needed to come down, to have him come down. By the time that we left the clinic at the end of the shift, I had not seen this patient.

When we arrived the following day, Security advised us that the patient had passed away during the night.

Danny Washington LVN

